33208

AVID Screen

Fax to: (206) 685-7569
or (800) 253-6404

Initial Screening: dyscrn01 ☐☐ / ☐☐ / ☐☐☐☐ ☐☐ ☐☐☐☐

Month / Day / Year / Site / Patient Acrostic

norsou01
1=North
0=South

First letter of first name and first 3 letters of last name.

1 Index Arrhythmia:

arrtyp01 PRIMARY means there is no evidence (even weak) that the event was due to transient or correctable cause

(check only one)

1 ○ (A) PRIMARY cardiac arrest due to VF
2 ○ (B) Documented sustained PRIMARY VT with syncope
3 ○ (C) Documented sustained PRIMARY VT, systolic BP < 80 mmHg or chest pain or near-syncope AND EF ≤ 0.40
4 ○ (D) Documented sustained PRIMARY VT, systolic BP < 80 mmHg or chest pain or near-syncope BUT EF > 0.40
5 ○ (E) Documented sustained PRIMARY VT, hemodynamically stable
6 ○ (F) Out-of-hospital documented sustained VT or cardiac arrest due to VF associated with transient or correctable cause

arrcs01 If (F) checked, indicate the most probable cause:

1 ○ (F.1) New Q wave MI
2 ○ (F.2) New non-Q wave MI
3 ○ (F.3) Antiarrhythmic drug reaction
4 ○ (F.4) Electrolyte imbalance
5 ○ (F.5) Cocaine or other illicit drug
6 ○ (F.6) Other

7 ○ (G) Out-of-hospital syncope with structural heart disease and EP inducible VT/VF with symptoms

2 Registry Exclusion Checklist:

Screen patient for all readily available information. Exclusions are not prioritized.
Check yes for EACH exclusion noted in the chart.

1 Yes	0 No		
○	○	(1)	Event occurred in-hospital within 5 days after myocardial infarction
○	○	(2)	Event occurred within 5 days after cardiac surgery or PTCA
○	○	(3)	Prior ICD implant or attempted implant
○	○	(4)	Intra-aortic balloon pump or other device or inotropic drug (not digitalis) necessary for hemodynamic support
○	○	(5)	NYHA Class IV heart failure
○	○	(6)	Currently on a heart transplant waiting list
○	○	(7)	Life expectancy < 1 year
○	○	(8)	Chronic serious bacterial infection
○	○	(9)	Inability to give verbal assent due to severe neurologic impairment
○	○	(10)	Died during screening

If ANY exclusion is checked YES, FAX only this form to the CTC. DO NOT complete a Registry form.

If ALL exclusions are checked NO, enter registry ID below, FAX this form to the CTC, and complete a Registry form for this patient. seqnum01 ☐☐ - ☐☐☐☐ - ☐

Signature of person filling out this form

☐☐☐☐ code number

For Clinical Trial Center Use Only:

☐☐ CTC Code | Yes ○ No ○ | 1 0 1 0 4 0 0 Screen page 1 of 1 | 1/31/95